DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01 — 26

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 0
b. FFY 2003 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A
Pages 4, 7, 11, 16, 20 & 24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A
Pages 4, 7, 11, 16, 20 & 24

10. SUBJECT OF AMENDMENT:
Methods and standards for establishing payment rates - Inpatient Hospital Care

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Janet Schalansky

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Secretary

15. DATE SUBMITTED:
12/20/01

16. RETURN TO:
Janet Schalansky, Secretary
Social & Rehabilitation Services
Docking State Office Building
915 SW Harrison, Room 651S
Topeka, KS 66612

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/26/01

18. DATE APPROVED:
MAR 08 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10-01-01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid & State Operations

23. REMARKS:
cc:
Schalansky
Day/Haverkamp
Co
DSG/DIATA

SPA CONTROL
Date Submitted: 12/20/01
Date Received: 12/26/01

FORM HCFA-179 (07-92)

Instructions on Back

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

1.0000 continued

y. "Readmission" means the subsequent admission of a recipient as an inpatient into a hospital within 30 days of discharge as an inpatient from the same or another hospital participating in the DRG reimbursement system.

z. "Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource use associated with all existing DRG categories and/or the creation or elimination of DRG categories.

aa. "Standard diagnosis related group (DRG) amount" means the amount computed by multiplying the group reimbursement rate for the general hospital by the diagnosis related group weight.

bb. State-operated hospital' means an establishment operated by the State of Kansas with an organized medical staff of physicians, with permanent facilities that include inpatient beds, with medical services, including physician services and continuous registered professional nursing services for not less than 24 hours of every day, and which provides diagnosis and treatment for nonrelated patients.

cc. "Stay as an inpatient in a general hospital" means the period of time spent in a general hospital from admission to discharge.

dd. "Transfer" means the movement of an individual receiving hospital inpatient services from one hospital to another hospital for additional related inpatient care after admission to the previous hospital or hospitals.

ee. "Transferring hospital" means the hospital which transfers a recipient to another hospital. There may be more than one transferring hospital for the same recipient until discharge.

2.0000 Reimbursement for Inpatient General Hospital Services According to Diagnosis Related Groups (DRGs)

2.1000 Hospital Participation Effective Date

Effective with services provided on or after October 1, 2001, general hospitals will be paid in accordance with the Kansas Medicaid/MediKan Diagnosis Related Groups (DRG) Reimbursement System described in 2.0000 and 3.0000. This does not include state-operated hospitals. State-operated hospitals are discussed in 4.0000.

2.2000 Billing Requirements

This section describes variations in how billings should be made by hospitals.

2.2100 General Billing

Under the DRG Reimbursement System a hospital may bill only upon discharge of the recipient except as noted in subsections 2.2200 and 2.2300.

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385 Short stay neonates died or transferred (2 day maximum)
386 through 388 No longer used
389 Birth weight > 2000 grams, full term with major problems
390 Birth weight > 2000 grams, full term with other problems
391 Birth weight > 2000 grams, premature or full term, without complicating diagnoses
801 Birth weight < 1000 grams
802 Birth weight 1000 - 1499 grams
803 Birth weight 1500 - 2000 grams
804 Birth weight > 2000 grams, w/ respiratory distress syndrome
805 Birth weight > 2000 grams, premature w/ major problem

After the DRG number reassignments, all these claims became part of the total data base used for the DRG Reimbursement System.

Subsections 2.4100 through 2.4700 provide a discussion of the development of all the system components for use effective October 1, 2001. The discussion flows in the order of the steps performed for the computations involved. For example, the establishment of the data base (Subsection 2.4100) was necessary before cost determination (Subsection 2.4200), outlier claims had to be identified (Subsection 2.4300) prior to separating them out from the data base (Subsection 2.4410).

2.4100 Data Base

For developing the DRG relative weights, group payment rates, and other system components for use effective October 1, 2001, the Department used as data base the Medicaid/MediKan paid claims for services the eighteen month period ending in April, 2001. Certain claims were excluded from the data base while some others were modified before including in the data base as listed below.

2.4110 Claims Excluded from the Data Base

- crossover claims (Medicare paid by Medicaid).
- swing bed claims.
- claims paid from out-of-state hospitals.
- claims from transferring hospitals (in case of transfers, only the claims from the final discharging hospitals were included in the data base), except for DRG's 385 and 456.
- adjusted claims (in cases where a hospital resubmitted a claim with corrections, the original claim was excluded from the data base. Only the final paid claim was included).
- interim claims which could not be matched together.

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Section 2.4260 continued

	Routine	Ancillary
7/31/99		3.83%
8/31/99		3.60%
9/30/99	5.40%	3.38%
10/31/99	5.18%	3.15%
11/30/99	4.95%	2.93%
12/31/99	4.73%	2.70%
1/31/00	4.50%	0.00%
2/28/00	4.28%	0.00%
3/31/00	4.05%	0.00%
4/30/00	3.83%	0.00%
5/31/00	3.60%	0.00%
6/30/00	3.38%	0.00%
7/31/00	3.15%	0.00%
8/31/00	2.93%	0.00%
9/30/00	2.70%	0.00%
10/31/00	2.48%	0.00%
11/30/00	2.25%	0.00%
12/31/00	2.03%	0.00%

Dates for routine are based on the hospital FYE and for ancillary are based upon the discharge date.

These amounts are applied to routine data, ancillary charges had already been increased by hospitals at their discretion as newer claims data was submitted. Based upon a comparison of the cost to charge ratios used for ancillaries, ancillary cost to charge ratios have generally declined or held steady. Therefore, the adjustment for ancillary charges should only be from the date of the service rather than from the cost report.

The inflation used was based upon a review of various price indices, changes in utilization, changes in case mix, and other relevant information. The inflation rate specifically considers the use of newer cost reports and the continued anticipated decline in average lengths of stay which reduce the cost of the average Medicaid stay.

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2.4430 continued

Analysis

The relative weight of .6881 in this example means that this DRG is less expensive to treat than the average DRG (with a weight of 1.0000). In other words, it indicates this DRG costs 31.19% less in relation to average DRGs.

2.4440 Modification of Relative Weights for Low-Volume DRGs

If very few paid claims are available for a DRG, any one claim can have a significant effect on that DRG's relative weight, day outlier limit, cost outlier limit, and daily rate. A statistical methodology was used to determine the minimum sample size required to set a stable weight for each DRG, given the observed sample standard deviation. For DRG's lacking sufficient volume in the Kansas Medicaid/Medikan claims data base, the DRG weight was derived using an external data base, with preference given to DRG weights derived from populations expected to be similar to the Kansas Medicaid/Medikan population. Sources used were an average of four states all payer data from 1997 from Kansas, Colorado, Iowa, and Wisconsin, and HCFA Medicare weights where other alternatives were not sufficient.

Outlier thresholds and average length of stay statistics for DRG's with externally derived weights were set using the appropriate statistics from the same external source. For DRG's whose weights were derived from Federal Medicare weights, in which case published cost outlier thresholds are based on a substantially different formula than is used by Kansas Medicaid, a least-squares regression equation was used to estimate the outlier threshold, based on the DRG weight.

2.4450 Modification of Relative Weights for Selected DRG Pairs

In cases of DRG "pairs" - one DRG with complications and co-morbidity (CC's) and the other DRG without CC's - if the DRG without CC's was weighted higher than the DRG with CC's, the relative weights of both DRG's were replaced with the weighted average of the two relative weights.

2.4500 Group Payment Rates

The Kansas Department of Social and Rehabilitation Services determined group payment rates for the three general hospital groups discussed in section 2.3000. The group payment rates are used in conjunction with DRG relative weights and other components developed for the Kansas DRG reimbursement system to determine payment.

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2.4530 Medical Education Addition to Rates

For hospitals with medical education costs, the group payment rates were modified as follows:

Hospital Specific Rate = Group Payment Rate + Hospital Specific Medical Education Rate

The hospital specific medical education rate has two components, direct medical education (DME) rate and indirect medical education (IME) rate. These were computed using the Medicare methodology.

2.4600 DRG Daily Rates

The Department computed DRG daily rates for all DRG classifications. These rates will be used for computing reimbursement in cases involving day outliers, transfers, and eligibility changes (see subsections 2.5300, 2.5400, and 2.5600).

2.4700 Hospital Specific Medicaid Cost to Charge Ratios

The Department established a cost to charge ratio of Medicaid utilization of inpatient services for each hospital. This ratio shows a comparison of Medicaid reimbursable costs of general hospital inpatient services with the corresponding covered charges.

Cost to charge ratios (CCR's) were calculated using the cost reports submitted by hospitals and charge data from the claims database used to compute the DRG weights and hospital group rates.

These ratios will be used in the DRG reimbursement system to estimate costs of claims for determining whether the claims meet the cost outlier criteria (subsection 2.5110), and also to compute payment for cost outliers (subsection 2.5310). Please note these ratios should not be confused with the cost to charge ratios of various ancillary service departments computed in hospital cost reports.

2.5000 Determination of Payment Under the DRG Reimbursement System

This section provides policies and methodologies for the determination of payment in various situations under the DRG reimbursement system.

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Section 2.5320 continued

Total Claim Payment	= Standard DRG Payment	+ Outlier Payment
	= $11,995	+ $2,264
	= $14,259	

2.5330 Simultaneous Cost and Day Outlier Payment

If a covered general hospital inpatient stay is determined to be both a cost outlier and a day outlier, the reimbursement will be the greater of the amounts computed for cost outlier and day outlier.

Example of Payment for Simultaneous Cost and Day Outlier:

Data

Total Claim Payment for Cost Outlier...$14,219 (subsection 2.5310)
Total Claim Payment for Day Outlier....$14,259 (subsection 2.5320)

Analysis

The higher of the two amounts, $14,259, will be the reimbursement amount for the claim which meets both cost outlier and day outlier criteria.

2.5400 Payment for Transfers

When a recipient is transferred during a covered general hospital inpatient stay from one hospital to another hospital, or to a psychiatric or rehabilitation wing of the same hospital, the reimbursement to all hospitals involved in the transfer(s) will be computed as follows.

2.5410 Transferring Hospital(s)

The reimbursement to each transferring general hospital shall be the DRG daily rate for each covered day of stay. Total payment to each transferring hospital shall be no greater than the standard DRG amount, except where the transferring hospital is eligible for outlier payments.

2.5420 Discharging Hospital

The discharging general hospital shall be reimbursed the standard DRG amount. If the claim qualifies as an outlier, the discharging hospital shall be eligible for an outlier payment based solely on the length of stay at the discharging hospital.